CHAPTER 2

PSYCHIATRY: A TOTALITY IN ACUTE PUBLIC MENTAL HEALTH SERVICES

> In our era, the experience of madness remains silent in the composure of a knowledge which, knowing too much about madness, forgets it (Foucault, 1967: xiv).

The third condition that Touraine (1978: 85) identified as necessary to distinguish a social movement is that it must have an adversary. For the consumer/survivor movement in mental health, the adversary is psychiatry itself. The previous chapter established the central principal of the consumer/survivor movement's conflict with the adversary to be the way patients receiving acute psychiatric services are treated. Touraine's model of new social movements suggests that the conflict that gives rise to a new social movement is embedded in the concepts or ideology of the adversary. Therefore, this analysis of the consumer/survivor movement as a new social movement calls for an investigation into the theory and concepts of the adversary.

Chapter two explores the way in which the subject is conceptualised in psychiatric theory. This involves an analysis of the theory, concepts and methods that psychiatry utilises to conceptualise psychiatric problems, which has the consequence of objectifying the patient. It is argued here that what is at stake for psychiatry is the recognition of a legitimate object for medicalisation. The second part of this analysis, in chapter three, considers the implications of these concepts for the treatment of patients in the institutional setting of acute public mental health

services.

Identity through Opposition: The Patient as an Object

The Diagnostic and Statistical Manual of Mental Disorders (DSM IV) (American Psychiatric Association, 1994) claims that psychiatry utilises a phenomenological approach. The psychiatric profession claims that psychiatry utilises a multifactorial approach (Wilson, 1998). Conversely, accounts of those that utilise acute public psychiatric services indicate otherwise. Consumer/survivors claim, as alluded to in chapter one and which will be explored further in the next two chapters, that mental health professionals are dependent on the conceptual framework of diagnosis to 'understand' recipients of acute psychiatric services. A consequence of this methodological reliance on diagnosis in acute public mental health services is that patient's themselves are objectified as pathological.

In other words, the reliance on the scientific approach of diagnostic categorisation to 'explain' acute psychiatric patient's symptoms, without also employing a methodology of understanding, results a 'methodological confusion' as Plastow (1997) calls it, which means psychiatry mistakes the subject for an object. That is, the dependence on an objective legitimate scientific approach in psychiatry results in the patient being pathologised 'as' a mental disorder. As will be demonstrated in the next two chapters, the total reliance in acute psychiatric services on the 'scientific methodology' of diagnostic categorisation results in the person being objectified. The

consumer/survivor movement opposes the totality of this methodology in acute public psychiatric services, because there is no acknowledgement of the patient as a person.

The diagnostic process relies on the psychiatrist's judgement to assess a subject's mental status. The psychiatrist's failure to relate to the psychiatric patient's experience results in reliance on scientific explanatory terms to account for mental health problems, which means that the patient as a person has not been acknowledged, considered or addressed. This lack of understanding results in failure to engage with the psychiatric patient as a person. This pathologising has been referred to as a defence mechanism to justify avoidance of the psychiatric patient (Main, 1977).

As Kahr (1994: 76) says 'when we ourselves cannot think symbolically about the bizarre, we tend to distance ourselves from it through diagnosis and pathologisation'. This scientific conceptualisation of the patient as 'other' or 'different', labelled and diagnosed as a mental disorder, protects the professional from subjective involvement with the patient. In the process, dehumanising practices are justified and the identification of the needs of the patient as a subject is evaded.

The failure to recognise the patient as a subject occurs twice. First as the person's problems and concerns as they themselves see them are not recognised or engaged with, and secondly through the medicalisation and classification of problems in terms of mental disorder. In the process, the person classified as disordered is erased

and overwritten as a 'mental disorder' and as such, is eliminated as a legitimate human being. The importance of the link between being a legitimate human being and the denial of this status through diagnosis with a serious mental disorder is the focus of the consumer/survivor movement.

This is because this is the site where the person is lost. It seems that according to the medical approach, the person IS the diagnosis in the eyes of the clinician, mental health services, the public, and themselves. However:

> Segregating a person into who she is versus the disease that afflicts her makes some sense when the affliction is not a disease of an organ central to being the human one is. Calling mental illness a brain disease does not fit that description. Calling mental illness a brain disease—and a chronic, constitutional brain disease that—actually confirms every patient's worst fear: This problem bears witness to something fundamentally wrong with the person I am (Fancher, 1995: 285).

Creating the Object: Understanding and Explanation

To identify the process whereby the objectification of the subject in acute psychiatric services occurs, psychiatric theory and concepts will be explored for their implicit conceptualisation of the subject. To do this, a range of recently published and readily available texts will be explored *Oxford Textbook of Psychiatry* (Gelder, Gath & Mayou, 1996); *Textbook of Psychiatry* (Beumont & Hampshire, 1990)*; Student Psychiatry Today: A Comprehensive Textbook* (Cohen & Hart, 1995)*; Psychiatry* (Tasman, Kay & Lieberman, 1997); and a locally Melbourne edited collection, *Foundations of Clinical Psychiatry* (Bloch & Singh,

1994); and others. The influence of psychiatrist and philosopher Karl Jaspers' (1963) important text, *General Psychopathology* will also be considered.

Psychiatry acknowledges two ways of knowing or conceptualising patients' problems: 'understanding' and 'explanation'. These terms originated with Windelband and Dilthey. Karl Jaspers' (1963) first introduced the terms to psychiatry in his 1913 edition of *General Psychopathology*. 'Understanding' (*Verstehen*) refers to subjective appreciation. 'Explanation' (*Erklaerung*) refers to objective causal connections. Notably, he describes these different conceptions as polar opposite sources of knowledge. The Oxford Textbook of Psychiatry (Gelder et al., 1996), typical of other texts, identifies the oppositional nature of these two terms as the paradox at the heart of psychiatry.

> Psychiatry can be practiced only if the psychiatrist develops two distinct capacities. One is the capacity to collect clinical data objectively and accurately by history taking and examination of mental state and to organise the data in a systemic and balanced way. The other is the capacity for intuitive understanding of each patient as an individual (Gelder et al., 1996: 1).

Theoretically, these two forms of reasoning work together. Understanding in current texts is described as the intuitive response that psychiatrists as human beings bring with them into psychiatry:

> Based on our ability to empathise with the experiences of another, we are able to put ourselves in their shoes and to imagine how it must be to feel as they do (Szmukler, 1994: 11).

This perspective considers the 'other' person as a subject based on the meaningful connections the person has made between his/her experiences and the events experienced. This approach considers the

mental (or phenomenal) world of others: 'their thoughts, motives, intentions, feelings and their status as an experiencing self or agent' (Szmukler, 1994: 11).

Explanation is defined as the objective study of mental phenomena as scientific forms, in terms of causal and predictive relationships using knowledge of biochemistry of the brain. The person is not seen 'as a subject but as an object or organism' (Szmukler, 1994: 13), where recurring 'forms' of mental experiences, regularities or patterns are gathered into diagnostic syndromes.

Jaspers identified the subjectivity of the practitioner as central to diagnosis. He characterised the diagnostic process as involving the meeting of one psyche with another. Further, he claimed that the success of such a meeting depended on the willingness of the psychiatrist to be involved in the psychic life of his patient. The power of the psychiatrist depends upon empathetic listening and his/her ability to 'see and experience', and more specifically on the 'receptivity and complexity of such power' (Jaspers, 1963: 21). Jaspers (1963: 22) also stated that such experiencing needed to be codified, whilst, acknowledging that 'dispassionate observation misses the essence of things'. This is an argument for both detachment and empathy.

The intersubjective and interpersonal nature of psychological problems, diagnosis and treatment is highlighted in Jasper's text. He recognised the impact of the practitioner's own state of mind on his/her perception and the importance of the awareness of this perception. To achieve this

awareness he suggested psychiatrists ask themselves about their own process of reasoning by asking: 'what construction am I putting on them', and 'how do they affect my own conscious reality?' (Jaspers, 1963: 22). He avowed that: 'In order to appreciate facts properly we must always work on ourselves as well as on our material' (Jaspers, 1963: 22). Such wise advice is needful in contemporary practice.

Although understanding, or empathy, is considered by Jaspers to be essential in dealing with patients, it is considered inadequate to 'explain' mental disorders. To 'explain' clinical phenomena, psychiatry, refers to an array of factors that are claimed to play a role in the aetiology of psychiatric problems. Aetiological perspectives are important because the way a problem is conceptualised determines how it is treated. Psychological texts (Nevid, Rathus & Greene, 1994) rehearse these aetiological perspectives. These include the biological, behavioural, cognitive, family and socio-cultural perspectives. Psychodynamic and various psychotherapeutic schools of thought extend the list from existentialist to self-psychology to object relationships theory to neo-Freudian and to eclectic.

Moreover, psychiatry as a discipline claims to utilise a multifactorial causal model which acknowledges biological factors, psychological factors, and social factors in a 'biopsychosocial model' (Wilson, 1998) developed by George Engel and Adolf Meyer. Even so, what will be the focus of attention here is the condition whose presentation is most frequent and troublesome in acute psychiatric service: that is

psychosis.

The Failure of Understanding Psychosis

In contrast to most other mental disorders, psychotic disorders are considered to be not understandable. Nevertheless, psychosis, which includes schizophrenia and other major affective disorders together, constitute the leading cause of acute psychiatric admissions in State managed acute psychiatric inpatient programs (Victorian Psychiatric Services Division: Health and Community Services, 1995: 15). The other groups besides schizophrenia which come under the category of psychosis are major affective disorders, which include depressive (unipolar) and manic (bipolar) mood disturbance. Other psychotic disorders include delusional and acute transient psychoses, as well as tentative categories that do not satisfy the research criteria for inclusion as a diagnosis so appear as diagnostic categories in the Diagnostic and Statistical Manual of Mental Disorders' (American Psychiatric Association, 1994) appendix. The inpatient group also includes people on community treatment orders.

Jaspers considers psychotic phenomena as 'not understandable' in a meaningful way at all in either 'normal' or 'abnormal' people. For this reason, he argues:

> We can only resort to '*causal explanation'* as with phenomena in the natural sciences which, as distinct from psychological phenomena, 'are never seen 'from within' but 'from the outside' only (Jaspers, 1963: 28).

Jaspers determined the experience of psychosis to be due to 'genetic

and constitutional' factors. This instituted the current biological axiom in psychiatry to explain psychosis. Thus, his focus on the role of biology has informed the current conceptualisations of psychiatry.

Jaspers argued that there was no greater difference in the psychic life of human beings than that between the normal person and the psychotic. This difference he referred to as an 'abyss of difference'. Laing's alternative conceptualisation will be considered in chapter six. Though Jaspers differentiated the psychotic from what became known as the functional disorders, it is apparent from the recent literature that these differences are in name only.

A consequence of the failure to understand psychosis, there is an endorsement of the reliance on explanatory models. McGorry (1994: 222) recognises that this approach, particularly with people experiencing acute psychosis, means the loss of the capacity for empathy by professionals and that 'the objective approach will dominate over the subjective'. That is to say, from the psychiatrist's point of view, acutely psychotic psychiatric patients are not considered understandable (Jaspers, 1963) but rather as 'mad' or 'irrational'. In the words of a psychiatric registrar:

> My experience so far... (is that) it is extremely difficult when someone is floridly psychotic initially and has extremely poor insight; it is actually hard to have to-and-fro communication (Wadsworth & Epstein, 1996c: 161).

McGorry (1994) defines psychosis as a group of disorders that assumes a misinterpretation of reality. The symptoms include hallucinations, delusions, thought disorder, disorganised speech, and altered affect.

These symptoms are then interpreted to mean that the person is incompetent, and therefore his/her status as a person is under question. McGorry (1994: 221) highlights the paradox that though no cerebral dysfunction is diagnosable in psychoses, 'most psychiatrists believe that these syndromes are associated with disturbed brain function'.

The current reliance on a biological 'disturbed brain function' model to explain psychosis is marked by a deficiency in understanding. The central nervous system vulnerability model that psychiatry claims to utilise is an attempt to integrate stress and personality. The greater the vulnerability the less the stress required to precipitate the disorder. Psychiatry acknowledges a number of sources of vulnerability for psychosis such as genetic, neurodevelopmental, birth injury, viral, neurochemical, gender, drugs, stress, and sociocultural factors (Beumont & Hampshire, 1990; Bloch & Singh, 1994; Cohen & Hart, 1995; Cooper, 1986; Dakis & Singh, 1994; Gelder et al., 1996; Lidz et al., 1995; McGorry, 1994; Sims, 1995; Snaith, 1991).

However, as alluded to in the introduction, there are a number of philosophical problems with this approach, which are not directly addressed in contemporary psychiatry. The problems with the current reliance on the scientific explanatory approaches implied in psychopathology will be explored further.

Limitations of Methodology

Even though understanding is acknowledged as essential in the

introductory chapters of psychiatric texts, the theoretical discussions about understanding, explanation, formulations and aetiology fill only the first chapter or two of the theory books. The rest of the chapters are devoted to diagnosis, and the diagnostic categorisation of 'psychopathology'. The distinction between theory and practice is used to explain the reliance on the methods of natural sciences. But the distinction between 'explanation' and 'understanding' is not only a theoretical distinction but also a distinction of method.

> When the psychiatrist exercises the first capacity, he draws on his clinical skills and knowledge of clinical phenomena: when he exercises the second capacity, he draws on his general understanding of human nature to gain insights into the feelings and behaviour of each individual patient, and into ways in which life experiences have affected that person's development (Gelder et al., 1996: 1).

Psychiatry's practical reliance on explanatory methods has resulted in a focus on diagnostic categories in psychiatric texts, at the expense of models of understanding. The failure to conceptualise and theorise understanding is justified by a claim that understanding is a skill learnt from practice rather than textbooks.

> From a textbook, however, it is inevitable that the reader can learn more about clinical skills than about intuitive understanding... This emphasis on clinical skills in no way implies that intuitive understanding is regarded as unimportant but simply that it cannot be learnt from reading a textbook (Gelder et al., 1996: 1).

The separation of intuitive understanding and clinical skills demonstrates the failure to grasp the centrality of 'methodology' as the means to understanding, as Jasper has outlined in his philosophy of psychiatry. He suggests that methodology is central to and determines what knowledge can be gained. He identifies research methodology to be

central to the production of the object of study. The object is not a reality in itself but only a perspective.

> The object is therefore never reality as a whole but always something in particular, an aspect or a perspective, never the happening in its totality (Jaspers, 1963: 23).

Jaspers' critique highlights the limitations of an interpretation implicit in a methodology, central to identifying objects. In recognition of the importance of methodology in the identification of an object, the task at hand is to examine the methodologies utilised in current acute psychiatric practice and consider their conceptual limitations.

Psychopathology as Totality

Mental disorders are considered to be due to pathology. The *Concise Oxford Dictionary* (Pearsall, 1999: 1045) defines pathology as a branch of medicine concerned with the cause, effect and nature of disease. According to *Taber's Cyclopedic Medical Dictionary* (Thomas, 1979), pathology refers to the study of a condition produced by a disease. Disease is defined as a pathological condition with abnormal and peculiar symptoms. Illness also has connotations of disease and presumes pathology.

An influential psychiatrist, Lewis (1963), defined the psychopathology of mental illness as evidence of the disturbance of 'part functions' as well as general efficiency. Gelder (1996: 77) attempted a more specific use of the terms. 'Part functions' he defined as a reference to 'perception, memory, learning, emotion and other psychological functions'. Disease he referred to as 'objective physical pathology' and illness as 'subjective

awareness of distress or limitation of function' (Gelder, 1996: 77). Gelder goes on to question the use of pedantic terms in mental health because by his definition they are not due to pathology but illness.

> This distinction has little bearing on psychiatric disorders since most of them have not demonstrable physical pathology. Most psychiatric disorders are best regarded as illnesses (Gelder et al., 1996: 76).

In spite of the reliance on the notion of pathology in texts of mental illness, there is limited evidence upon which to base the conception of mental health problems as biological. Goldstein (1997) asserts, after a thorough review of the current literature on biological research, that:

> The aetiology of most, if not all, of the mental disorders will be at the systemic level, and will require new conceptual models as neural networks for further theoretical development. It seems now that the definitive biological factors may be at the level of dendritic coding or architecture, cell membrane metabolism, or complex genetic variations that are not of the single gene type. Indeed, intensive genetic investigation indicates that there is no gene for schizophrenia (Goldstein, 1997: 320).

In other words, the common yet problematic claim in psychiatry is that mental disorders are biologically derived at the level of the biological functioning, which includes biochemistry. However, there is only limited evidence to substantiate this claim. The interpretation of postmortem studies does not provide support because changes could have occurred after death, or have been due to drug treatment. For instance, the increased number of dopamine receptors found in those with schizophrenia could be due to drugs, which block dopamine receptors, or receptors may be a compensatory mechanism acting in response to another neurotransmitter. The dopamine hypothesis has been questioned with the introduction of new generation drugs, as they work

very differently. The use of magnetic resonance imaging for biochemical studies is also a limited form of evidence, as evidence from these studies may show a process but not necessarily a cause.

The utilisation of a medical metaphor has been promoted in an attempt to destigmatise, though for the patient, the implication of a polluted gene pool has had the opposite effect. The implications of biological reductionism are depressing.

> To say that a person is constitutionally, genetically, chronically impaired biologically is to say that the person is chronically, genetically impaired as a person. How is that supposed to help increase tolerance of the mentally ill? (Fancher, 1995: 284).

The medical training of psychiatrists maintains the medical understanding or axiom of psychiatry. The problem with this perspective is that it is presented as fact, as already substantiated by research, to patients, practitioners and the public. As Fancher (1995) has stated:

> So long as the devotees of biological psychiatry acknowledge the difference between their hypotheses and the results of their work, we can only wish them well (or ill, as may be our wont). What is objectionable is the attempt to persuade patients, the public, and clinicians (especially psychiatrists) outside the research community that the scientific work has already shown the [psychiatry's] culture's agenda to be correct, capable of fulfillment, and significantly fulfilled (Fancher, 1995: 255-256).

Fancher (1995) also points out the logic of biological psychiatry is contradictory as monism is argued for on the one hand and dualism on the other. Material reduction is argued for in that it is argued that biology alone accounts for aetiology, but this also invokes a dualism as the affect of other factors such as the social, developmental on biology

are discounted. [1]

Diagnostic system

A central aspect of psychiatric objectification is the diagnostic system. The diagnostic system itself relies on a medical conceptualisation of psychiatric disorders. The system utilises an explanatory model, where

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[1] Current research and philosophy recognise that many factors affect biology: that is, biology is seen as an effect, rather than the cause of a broader problem (Mishara & Schwartz, 1997). But clearly: 'This philosophical line necessarily implies the need for a change in the attitude of the psychiatrist himself' (Naudin et al., 1997: 393). Furthermore, Pilgrim and Rogers (1993) list five reasons for reliance upon medical treatments for psychiatric problems.

Firstly, the treatment of madness has long involved doctors with biological treatments. Alternatively, if this is not the case, mental illness is a social problem, and providers of talking treatments would not be required to be physicians. Secondly, the shift to rejoin psychiatry with mainstream medicine in the general hospital by the process of deinstitutionalisation has tended to compensate for psychiatrists' previously low status, and made physical treatments for psychiatric disorders more credible, by being consistent with other types of medical procedures. Thirdly, drug treatments are legitimised and encouraged by the profit motive. In 1992 in Britain, twenty four percent of all scripts were psychotropic drugs. Fourthly, cost control treatments. Drugs are cheaper than labour intensive psychotherapy. Medical visits are viewed as commodities on a production line (Hart, 1992). Efficiency is gauged by the number of patients processed per unit of time, however destructive that is to the relationship between the doctor and the patient (Eisenberg, 1995: Graham, 1994). Fifthly, physical treatments such as drug treatment and electroconvulsive therapy, even straitjackets and confinement, can be imposed without cooperation or consent, while psychotherapy cannot.

symptoms are conceptualised as forms and studied as mental phenomena, the premise being that the cause is biological. The DSM IV (American Psychiatric Association, 1994) is an attempt to contain the complexity and standardise diagnostic practice. The DSM IV presents symptoms, grouped together into a syndrome and thus used as criteria to diagnose mental disorder. The DSM IV claims to be 'atheoretical', 'objective' and 'neutral' and to utilise a phenomenological approach. Thus it defines a mental disorder as:

> A clinically significant behaviour or psychological syndrome or pattern that occurs in a person and that is associated with present distress (painful symptom) or disability (impairment of one or more important areas of functioning) or with a significantly increased risk of suffering or death, pain, disability, or an important loss of freedom (APA, 1994: xxi).

The DSM IV's claim to being atheoretical is naïve because any classificatory system requires a conceptual framework. The first two editions of DSM were based on psychoanalytical concepts of neurosis and psychosis, which are still informally used today. The division refers to a qualitative difference in symptoms. A defining feature of psychosis is lack of insight, the failure of the person to recognise that they are ill and need treatment. The marked difference between psychosis and neurosis according to Gelder [1996: 61) is 'the patient's ability to distinguish between subjective experience and reality, as evidenced by hallucinations and delusions'.

Gelder acknowledges that the use of psychosis as a term is difficult to apply, because of the difficulty of the definition, and because it refers to a broad group of disorders. Psychosis and neurosis are currently used

in order to determine what drugs will be used to control them. This is especially the case when a provisional diagnosis is made, such as when the choice is between schizophrenia and mania, or 'psychotic disorders not otherwise specified'. Psychosis and neurosis have been abandoned in the DSM III, III-R and IV in preference for the defining of specific disorders (Gelder et al., 1996).

The analytic approach fell into disfavor in the United States, in the face of the difficulty of diagnosing mental disorders consistently as evidenced by the *International Pilot Study on Schizophrenia* (World Health Organisation, 1973). Since then, Jasperian notions of a phenomenological approach in relation to mental disorder have been utilised, where understanding people's subjective experience is claimed to be considered as central. The claims of the DSM III, III-R and IV to attempt to utilise a phenomenological approach explain the inclusion of the terms behavioural and psychological in the DSM IV's definition of mental illness.

Diagnosis

Each mental disorder in the DSM IV is a group of symptoms arbitrarily grouped together and called a mental disorder. Diagnoses are basically hypotheses based on groups of symptoms called syndromes. There is nothing that defines these symptoms as a group. The diagnostic categories are not discrete groups. There is nothing external that verifies, identifies or defines them. They are only hypotheses that guide research. This means that the validity of the disorder is questionable,

and yet it is not treated as such.

> Whole industries of research effort are devoted to classifying and reclassifying categories of psychiatric disorders and revisions of systems are published. The disorders appear in neat lines on the printed page and this procedure provides a general sense of professional security, a structuring of uncertainty and chaos. This comfort lasts only until it is realised that all these categories may coexist, that in fact they are not separate from each other—a phenomenon for which the jargon, 'comorbidity' has been introduced (Snaith, 1991: 129).

Yet, diagnosis is what psychiatrists are trained to do. And it is the diagnosis that determines treatment and outcome. Therefore, a person's symptoms are reinterpreted as evidence to support a diagnosis. This reading of symptoms invalidates a person's personal account. The availability of categories of diagnostic systems does not provide understanding for the person, but does explain the way that providers of acute mental health services listen to their patients. What are listened for are symptoms that will fit specific diagnostic criteria. These criteria are essentially arbitrary, but have extreme consequences for the person receiving the diagnosis, because professionals inadvertently conflate the person with the diagnosis.

Even if a psychiatrist in the public mental health service does not personally adhere to the biological model, the mental health service system requires that the patient be diagnosed for treatment in the mental health system, which means the outcome is the same for the patient: objectification. This will be examined further in chapter three.

Healy (1990) claims that psychopathology has been abandoned in preference for psychiatry as a practice based on DSM IV criteria. This claim is made in the face of the acknowledgement amongst psychiatrists

that ‘diagnosis alludes to aetiological factors’ (Dakis & Singh, 1994: 9). The DSM IV’s claim that the categories are ‘descriptive’, and that symptoms fall into ‘natural’ categories is an attempt to bypass the problems of aetiology altogether. Yet the DSM is considered necessary to generate theoretical concepts for causes of mental disorders, which can then be described, researched, evaluated, communicated, and used to predict outcomes (American Psychiatric Association, 1994: xv-xvi). The strict criteria and simple format of the DSM were intended to redeem psychiatry by making diagnosis a science, which has largely been effective.

However, it seems that the manufactured construction of the diagnostic system is not apparent to many of those who use it. While psychiatrists may well acknowledge these problems and limitations, the mental health service system itself does not accommodate the limitations of the approach by providing resources to overcome the limitations of the present diagnostic system. This would mean providing services that utilise different conceptual tools and models. Currently, through the total reliance on the approach of psychiatry in acute public mental health services, the message to the patient and the public is that the current approach is adequate in its totality. The limitations and compensations for these limitations are not acknowledged, much less addressed.

Even so, the categorical organisation of symptoms is perpetually under dispute. An example is the dispute about the different categories of

psychosis, such as psychotic depression and schizophrenia, which are often difficult to differentiate. The two are often also mixed in a person's family history. This fundamental uncertainty is problematic considering the assumed legitimacy of diagnostic categories, and how central these classification systems are to mental health services and the impact that such labels have on patients' identities.

Moreover, psychiatric philosopher Jennifer Radden (1996) argues aetiological assumptions work to limit approaches to research.

> Questions about aetiology implicate philosophical and theoretical assumptions reinforcing diagnostic classification involved. In an important review of the findings... distinct syndromes may prevent a discovery of the causal correlationships involved (Radden, 1996: 366).

Radden (1994) goes on to argue elsewhere along with other philosophers of psychiatry (Caws, 1994 and Fulford, 1994) that the current DSM IV is far from satisfactory. The assumptions it relies on are obscure and undefined. For instance, what exactly constitutes a mental disorder is difficult if not impossible to define. The problem is that the area of interest of psychiatry, that of the mental or the mind, cannot be seen or observed directly. What 'the mind' is or how it functions is not known. What constitutes the mind is presumed to happen in the brain.

Clinical Phenomenology and Mental Illness

Despite the DSM IV's claim to a phenomenological approach, the phenomenology of the DSM IV is not what Jaspers referred to. As the above outline indicates, the subjective phenomenology of Jaspers has been reconfigured as 'objective' evidence. This is evident in the criticism

of the DSM IV today 'modern classifications give too little attention to the deep meaning of subjective experiences as well as to the patient's life history' (Naudin et al., 1997: 391). Sims (1995) *Symptoms in the Mind: An introduction to Descriptive Psychopathology* highlights that even though the Diagnostic and Statistical Manual of Mental Disorders (DSM) claims to be based on phenomenology, it is a reversal of Jaspers definition of phenomenology.

Jaspers differentiated subjective phenomenology from objective phenomena. Objective data can be observed and tested. For evidence called objective in mental health, this is not the case. Subjective phenomenology, such as that which is experienced by the patient can only be reported on by the patient and therefore observed indirectly. The subjective experience of hallucinations and delusions are misconstructed in the DSM IV as objective criteria. Subjective phenomenology is unobservable, untestable, and inexplicable, and relies on the subjective judgement of someone else to validate the experience. Significantly, Jaspers also maintains that revelation of such subjective experiences requires empathy.

Moreover, clinical phenomenology in psychiatry has been assumed to be representative of underlying neurobiology, but this claim is unsubstantiated. In three independent empirical studies of neuropsychology and diagnosis, no relationship has been found. That is, neuropsychological tests do not necessarily support diagnostic categorical claims (Goldstein, 1997). Cohen argues that psychiatrists

recognise that:

> Clear diagnostic entities exist only in textbooks and that in clinical practice, few patients fit neatly into one category or another. Consequently, this leads to unreliability in psychiatric diagnosis, and to unrealistic assumptions being made about disease categories. Furthermore, making a diagnosis of depressive disorder or schizophrenia conveys nothing about the uniqueness of the individual, nor how interpersonal problems, personality factors, childhood experiences and life events may have contributed to his current state (Cohen & Hart, 1995: 11).

Jaspers' (1963: 55) phenomenology is 'the study which describes patient's subjective experiences and everything else that exists or comes to be'. And despite the claim that phenomena is always individual, and cannot be directly observed, Jaspers sets out to:

> Give a concrete description of the psychic states which patients actually experience and present them for observation. It [phenomenology] reviews the inter-relationships of these and delineates them as sharply as possible, differentiates them and creates a suitable terminology (Jaspers, 1963: 55).

The goal of phenomenology is according to Jaspers (1963: 56) to find out 'what is really happening in our patients, what they are actually going through, how it strikes them, and how they feel'. The basis of this phenomenology is self-description which relies on the 'psychological judgement of the patient himself' (Jaspers, 1963: 56).

This would seem to be an ideal approach. Yet, this next statement by Jaspers pinpoints the site of the fundamental weakness in the current approach of psychiatry.

> We are not concerned at this stage with connections nor with the patients' experience as a whole and certainly not with any subsidiary speculations, fundamental theory or basic postulates. We confine description solely to the things that are present to the patients' consciousness (Jaspers, 1963: 56).

In this statement, Jaspers has differentiated the social context of

peoples' experience from psychiatry's role in the diagnosis of the problem. This distinction has resulted in a failure in psychiatry to recognise the role of context in precipitating peoples' problems. This also accounts for the dominant role of diagnosis in psychiatry. The decontextualisation of symptoms in psychiatry is a false one, as Laing in chapter six demonstrates, and explains the lack of understanding in psychiatry.

The distinction between experience as a whole and subjective experience inparticular also explains the failure to discuss the ambiguities of the symptoms of delusions and hallucinations in the major texts (Sass, 1994). These 'symptoms' are instead treated as disconnected categories that are definable in a context independent manner (Parnas & Bovet, 1995). The implicit questions regarding the theory of mind are not accommodated in the 'scientific' approach and are therefore not discussed. Today's psychiatry is based on a common clinical usage of the term 'phenomenology' to refer to 'objective' signs and symptoms, as in phenomenological psychopathology. Current texts do not discuss the historical roots of the terms such as 'phenomenology' or 'descriptive psychopathology' or the categories of the mental state examination. There is no discussion of how, where or when they originated or if they are appropriate or useful.

Mulder (1993: 559) argues psychiatrists need to be aware of the historical, cultural, legal, religious, medical and educational knowledge's and disciplines to make sense of psychiatry, otherwise

there is a 'danger' that trainees will learn a simplistic application of diagnostic criteria and management techniques, and 'how to mesh them together'. Mulder (1993: 559) complains: 'there is an even greater danger that they will believe them [diagnostic category] absolutely'. Naudin (1997: 391) suggests: diagnostic classifications give insufficient attention to the subjective meaning of symptoms and life histories.

If the philosophical discussions of psychiatry are anything to go by, it seems that phenomenology is making a comeback (Mishara & Schwartz, 1997; Naudin et al., 1997). There is an acknowledgement that philosophically at least, a phenomenological approach is potentially productive (Sims, 1995). Current philosophy indicates the move to recognise the role of multifactorial factors affecting biology, such that biology is seen as an effect, rather than the cause of a broader problem (Mishara & Schwartz, 1997). However, 'this philosophical line necessarily implies the need for a change in the attitude of the psychiatrist himself' (Naudin et al., 1997: 393). Furthermore, whether 'behaviour' is interpreted as a symptom is dependent on social mores. The criteria that define symptoms as disorders has changed over time, depending on the theoretical model in vogue by those responsible for decision making.

For example, homosexuality was and now is no longer a 'mental disorder'. Attention deficit disorder was not and now is a 'mental disorder'. The ever increasing list of 'mental disorders' constitutes a growing list of behaviours as symptoms that are subject to diagnosis or

labelling as 'mental disorder'. The logic is cyclic; diagnosis depends on labelling of symptoms considered a 'mental disorder'. The symptoms that occur outside one syndrome are either disregarded, or are considered to indicate comorbidity. For example, hallucinations and delusions, two defining features of schizophrenia also occur in depression, post traumatic stress disorder, and other disorders. What is considered diagnostic criteria is not necessarily valid, but arbitrary.

Jaspers' analysis is critical of the tendency in psychiatry to confuse knowledge and belief as what is observed is informed by value judgements. For instance, the desire to understand leads to the search for a rational explanation while the reliance on causal explanation means that the human experience itself is ignored. This approach, Jaspers suggests, fails to acknowledge that we cannot see psychic life. Psychic life is an experience. In discussing it we need to rely on layers of imagery, metaphor and simile. It seems that what has happened in contemporary psychiatric practice and research is that these similes have been taken for granted as fact. The breaking down of the psyche into mechanistic, biological, biochemical, electrical, genetic and hormonal factors, have come to be seen as a certainty, rather than possible influences on psychic life.

Psychiatric categories work, according to Jaspers, to prejudicially influence how we think about psychiatric problems. He goes on to say that prejudice relating to quantitative assessment, objectivity and diagnostics derives from the natural sciences where: 'qualitative

changes are regarded as arbitrary, subjective and not scientific'. Even though Jaspers' first edition of this *General Psychopathology* was in 1913, and the last revision in 1963, these comments are true of today's practice.

Jaspers also warned of confusing individual cases with probabilities, an injunction, which is formally transgressed in the diagnostic process. This process involves a professional consensus about what symptoms should be grouped into what category. These are then formulated into diagnostic criteria of mental disorders which are presumed to be representative of the individual's experience. The criteria are assumed to represent the disorder, yet without a 'gold standard test' (Office of the Chief Psychiatrist, Mental Health Branch, Department of Human Services, Victoria, 2000). Categorising is a way of representing what is not understood. The statistical evidence about how these symptoms may coincide in people does not predict what treatment is appropriate for individual persons.

The phenomenology of the DSM IV practiced within acute psychiatry today makes the experience of the psychiatrist, rather than that of the patient, central. Diagnosis is based on the doctor's subjective experience, which is the only instrument a psychiatrist has to diagnose problems. The reliance upon the professional's subjective 'intuitive' sense to diagnose the patient as psychotic is counter-productive, because it is devoid of a method of understanding. The patient's reported symptoms are interpreted bereft of empathy, within the frame

of the scientific methodology required for diagnostic categorisation. The absence of a methodology of understanding decontextualises and pathologises the experience of the patient.

This conceptual framework betrays the 'great personal significance' (Watkins, 1998) patients place upon their experience. This betrayal works against the establishment of rapport so essential for a therapeutic relationship. A therapeutic relationship is not what psychiatry offers for the public patient in acute mental health services, where public mental health services funding, practice and teaching limit treatment to the mainstream medical practice of psychiatrists: diagnosis and drugs. It seems that for acutely distressed people experiencing psychosis, expecting to be understood is out of the question as there is not a model of understanding in place for practice.

The perception of the patient as suffering an objective problem of mental disorder means that the meaning or subjective content is not considered relevant. It seems that psychiatric training and concepts, 'cultures out' understanding in favour of the more 'sophisticated' explanatory approach to psychiatry. Perceiving the person's feeling, state and behaviour as objects to be studied means that the subjective experiences of the person concerned is considered irrelevant to acute psychiatric hospital practice. Such is the violence of the label 'mental illness': once diagnosed, the person as a person ceases to exist. The person becomes the diagnosis. What has been demonstrated here is that the current conceptual model is inadequate to understand, much

less accommodate, patients' needs, and makes clear the methodology whereby the experience of the patient is considered not relevant.

Conflicts over 'The Subject'

Nonetheless, professionals consider the conceptual framework utilised in psychiatry legitimate. The use of diagnostic classification in regard to the person subject to diagnosis is defended on a number of grounds. Classification is justified as a scientific activity, worthy of merit. And while there are those who find comfort in having a label for their disorder and experience, the practice of diagnosis itself is reductive, as the diagnosis becomes the explanation and short circuits the attempt to understand the person and their specific needs and experiences.

The professional diagnosis of 'psychosis' also justifies or rationalises the evasion of the psychiatric patient by the professional, by providing a rational explanation for what is otherwise considered 'not understandable'. Main (1977) points out, diagnosis is an intellectualisation, a defence against the psychiatrist's own subjective involvement with the 'mad'. The problem is the failure to acknowledge the limitations of psychiatric concepts, and the inadequacies of the approach for conceptualising what patients are experiencing. The limitations of psychiatric concepts reduce its generality and applicability; however, society continues to look to medicine for totalising frameworks which result in further negative implications. This is not to say that psychiatry and psychiatric diagnosis and treatment do not have a place, but a call to recognise and address the limitations of

this conceptual framework.

The present classificatory system also limits research as the implicit philosophical and theoretical assumptions restrict further research to those areas which substantiate (or as is in the case-fail to substantiate) the current theoretical and conceptual approach. This reliance on current conceptual models, Jennifer Radden (1996: 366) argues, 'may prevent a discovery of the causal correlationships involved'.

The failure to explore the disjuncture between theory and practice has negative implications for patients. There is a failure to acknowledge what psychiatrists themselves know to be 'true': that first and foremost there is a person to engage with and respond to and not a diagnosis. But this is not the experience of patients on acute psychiatric wards of public hospitals. It is inappropriate and unrealistic to expect psychiatrists to learn that the patient is most important if there is no model of understanding conceptualised, taught or practiced in acute psychiatric wards of public hospitals, the training ground of psychiatrists.

The failure to identify the context, the connections and meanings the patients themselves have identified, is to miss a great deal, as philosophers before and since Jaspers have identified. Jaspers (1963: 58) himself identified 'immediate experience is always within a total relational context' which he suggests, needs to be dissected to describe phenomena. Nonetheless, this 'relational context is founded on the way we *experience space and time* in the mode of *body-awareness* and the

awareness of reality' (Jaspers, 1963: 58).

Jaspers noted:

> Human beings are creatures of culture, they develop beliefs and moral standards and constantly transcend their own empirical human self which is the only self that scientific research can recognise and grasp (Jaspers, 1963: 8).

Jaspers appreciated the defining characteristics of a person to be a product of biology and environment. He says that the self arises when confronted with *frontier-situations:*

> the final frontiers of existence—death, chance, suffering, guilt. These may awake in him something we have called Existence itself—a reality of selfhood (Jaspers, 1963: 12).

The consumer/survivor literature indicates that admission to an acute psychiatric service would be considered such a critical moment. And, in the context of Jaspers' philosophy, this provides an important opportunity for the consumer/survivor to deal with their sense of self. Though this is not what happens in the services supposedly designed for such problems, the concepts required to do so will be discussed in chapter six through the work of Charles Taylor and Paul Ricoeur. Nonetheless, Jaspers acknowledges the role of the mind and the spirit involved in psychic illnesses. He argues humanness alone to be vulnerable because of the freedom and possibilities associated with the subjective experience of consciousness and self-reflection. Such that 'man is not merely pattern, he patterns himself' (Jaspers, 1963: 8).

There is a conflict of interest in psychiatry. An acutely distressed person wants to be heard, and listened to, so that his/her utterances may not be taken as a form or a symptom to be diagnosed, but as an account of

a person. Laing argues that the problem for a person with schizophrenia is that they have never felt loved, and so experience desperation and aloneness.

> The schizophrenic is desperate, is simply without hope. I have never known a schizophrenic who could say he was loved…We have to recognise all the time his… separateness and loneliness and despair [Laing, 1965: 38).

One of Laing's patients said:

> It feels so much better to be able to share the problem with someone, to have him understand how badly you feel. If you're not alone, you don't feel hopeless any more. Somehow it gives you life and a willingness to fight again (Laing, 1965a: 165).

There is acknowledgement within psychiatry of the therapeutic benefit of being listened to. As Mohl (1997) states:

> There is nothing more healing than the experience of being found by another… Psychiatric patients, deep inside, have lost or never had that experience. However obnoxious, destructive or desperate the overt behaviour, it is the psychiatrist's job to seek and find the patient. That is the purpose of listening (Mohl & McLaughlin, 1997: 11-12).

Laing (1965a: 32) argues that it is the psychiatrist's responsibility to see the world from the patient's point of view, as 'expressive of his mode of being-in-the-world, which requires us to relate his actions to his way of experiencing the situation'.

However for patients to be apprehended as persons, a re-conceptualisation of the patient as a subject is required as one who is not merely ill, an 'object' or as mentally disordered. [2] Consumer/

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[2] Yet, for those requiring access to resources such as income, support services, housing etc., much depends on fitting into a suitable diagnostic category. This puts the person in a double bind: if the diagnosis is not accepted the resources are not

survivors themselves are providing a space for patients' concerns to be listened to and accepted as legitimate, which opens up new possibilities. Consumer/survivors themselves are mobilising for change by taking up their perspective in a political movement in an attempt to have their voices heard and understood.

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made available, if it is accepted the resulting stigma is debilitating (Even so, access to resources are not guaranteed as the people living with psychosis study indicates (Jablensky et al., 1999a; 1999b).